

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022870
STATE FILE NUMBER
2 5683

FILED JUL 2 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>St. Louis</i>		c. CITY OR TOWN <i>ST. LOUIS</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>City Hospital</i>		d. STREET ADDRESS (If outside, give location) <i>1616 1/2 Cole</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Addie L Fenner</i>		4. DATE OF DEATH Month Day Year <i>June 11, 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 7, 1900</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>59</i> Months Days Hours Min <i>2 AM</i>
13a. FATHER'S NAME <i>Lid Webb</i>		13b. MOTHER'S MAIDEN NAME <i>Jennie Barba</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		17. INFORMANT <i>William Fenner</i>	14. NAME OF HUSBAND OR WIFE <i>William Fenner</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO (b) <i>Coronary Sclerosis</i> DUE TO (c) <i>4201</i>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Paul Simon Crowe</i>		22b. ADDRESS <i>1300 Clark</i>	22c. DATE SIGNED <i>6/12/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>17-6-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>National Cem. Jefferson Bl</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Missouri</i>
24. FUNERAL DIRECTOR <i>F. A. Green</i>		25. DATE RECD. BY LOCAL REG. <i>JUN 15 '59</i>	26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *F. A. Green*

Licensed Embalmer No. *2963*

P. O. Address *4214 Salzman*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.